PATIENT CONTACT AUTHORIZATION

PLEASE NOTE THAT PRACTICE DOES NOT DISCLOSE OR SELL ANY PATIENT PROTECTED HEALTH INFORMATION TO ANY THIRD PARTY BUSINESS OR ONLINE DATABASE.

I, the undersigned, authorize MVM Health – Pain, Vein & Wellness ("**Practice**") to contact me according to the policies of Practice regarding facets of my care, including requests for information, verification of payment or benefits, or reminders for appointments. I understand and accept that Practice may leave messages on my home or cell phone answering system or send reminder cards by U.S. mail, email, or text message according to the policies of Practice.

If Practice needs to communicate with me regarding my treatment, my preferred method of communication is as follows (check one):

☐ Phone call _____ ☐ Email_____

☐ Text Message _____ ☐ Other _____

I understand that if I have chosen a phone call as my preferred method of communication, Practice may be required to leave a voicemail for me regarding my treatment. In such an event, Practice should (check one):

☐ Leave a message with detailed information regarding my treatment.

☐ Leave a message requesting that I call Practice at a specified phone number.

I understand that from time to time Practice may utilize email or text messages to communicate with me both about my treatment and for marketing purposes. I understand that these emails or text messages may include appointment reminders, general health reminders, feedback requests, newsletters, and other information relating to Practice. Accordingly, I (check one):

☐ Authorize Practice to **email** me for both treatment and marketing purposes.

☐ Authorize Practice to **email** me appointment and health reminders only.

☐ Authorize Practice to **text** me for both treatment and marketing purposes.

☐ Authorize Practice to **text** me appointment and health reminders only.

☐ Do not authorize Practice to email or text me.

I understand that this authorization will remain in effect until I either submit a subsequent Patient Contact Authorization changing my above stated preferences, or I revoke this authorization in writing. To do so, I must send written notice of revocation to Practice at 296 East Brown Street, Suite D, East Stroudsburg, PA 18301; call Practice at (223) 213 - 2084; or utilize the opt-out or unsubscribe options included in any authorized text message or email contacts.

I acknowledge and agree that Practice, its employees, officers, and staff are released from any legal responsibility or liability for or resulting from the authorized disclosure of my health or billing information.

Printed Patient Name **Date**	**Signature of Patient**
Practice Representative Name **Representative/Witness**	**Signature of Practice**